ASSOCIATION of MIDWIVES of NEWFOUNDLAND & LABRADOR

Newsletter No. 53, September 2010

Association of Midwives of Newfoundland and Labrador
(Chapters in Goose Bay and St. John's)
Newsletter 53
September 2010

MISSION STATEMENT
To provide opportunities for information sharing between midwives and to promote the profession of midwifery and the need for appropriate legislation so that midwives in Newfoundland and Labrador are publicly funded to provide evidence-based midwifery care for childbearing families in this province. (2005)

This Newsletter contains the minutes and reports from the General Meeting held in September. There is an update of what is known about regulating midwifery in this province. There are only two provinces without regulated midwifery and Newfoundland and Labrador is one of these. In October there was the Canadian Association of Midwives annual conference in Edmonton and at the same time an AIT Labour Mobility meeting was held. Some notes from these are included. These have all contributed to this newsletter being late.

At the back of the Newsletter is a membership form and fees are due January 1.

The Newsletter editor welcomes midwifery news items. Those who submit items are responsible for obtaining permission to publish in our Newsletter. The Editor does not accept this responsibility. Items for the next Newsletter should be submitted by the end of December. Reports of meetings and conferences related to maternity/obstetric care would be welcomed.

Pearl Herbert, Editor, (pherbert@mun.ca)

AMNL General Meeting,
Monday, January 17, 2011 at 4:00 p.m. (Island time)
In St. John's the conference call will be taken at Telemedicine/PDCS, HSC.
(The call may be taken at other Canadian locations, but please share a phone line if there are two or more people calling from the same community.)
Contact Pearl Herbert for the Pass Code.

Canadian Association of Midwives
Annual General Meeting and Conference November 9-12, 2011
Joint conference with MANA and ACNM at Niagara Falls, ON
(www.canadianmidwives.org)

Executive Committee

President: Pearl Herbert (pro tempore)
Secretary: Karene Tweedie
Treasurer: Pamela Browne
CAM representative: Kay Matthews
Newsletter Editor: Pearl Herbert
Web page: http://www.ucs.mun.ca/~pherbert/

On leave: Karene Tweedie,
Minute Recorder: Susan Felsberg
Cosigner: Susan Felsberg
Past President: Kay Matthews

Newsletter in HSLibrary:

Summary of the General Meeting, September 13, 2010

There were eight members present. Information about the Health Professions Act and subsequent meetings was given so that it could be Minuted. For the International Day of the Midwife May 5, the Friends of Midwifery consumer/lobby group and the Doula Collective held a film event on May 4. Kay Matthews and Pearl Herbert attended and reported an audience of nearly 100. Following the meeting it was noted that there are six of the midwifery DVDs left (contact Kelly Monaghan, past coordinator of Friends of Midwifery to obtain one of these).

The Personal Health Information Act was passed in 2008 and it is expected to be proclaimed in December 2010. There was an information session on September 16, and due to other commitments Pearl and Kay would only be able to attend for the first hour of the meeting.

Friends of Midwifery

The new Coordinator of the Friends of Midwifery, is Katie Fitzpatrick, doula and nanny. Her address is 30 Fleming Street, A1C 3A2. Her cell phone is 691-2762.

AMNL Midwifery Regulations Committee

The four members of this committee, Karene Tweedie, Kay Matthews, Pamela Browne and Pearl Herbert have been busy revising and updating the 15 Midwifery Scope of Practice documents that were developed and accepted by the provincial Government's multidisciplinary Midwifery Implementation Committee 1999-2001.

In the last AMNL Newsletter the meetings up to July were reported. Since then there was a telephone conversation on August 6 with lawyer Suzanne Orsborn, Regulatory Development Consultant, Legislative and Regulatory Affairs, Department of Health and Community Services, who is working on the midwifery regulations. The need for midwifery to be publicly funded and the midwifery model were discussed, including the main pillars of continuity of care by known midwives, woman centred and informed choices including place of birth. Kelly Monaghan had contacted people and Karene Tweedie had contacted ARNNL regarding having a message in the September *ACCESS* for nurses with midwifery qualifications to contact AMNL.

August 30 Pearl and Kay were requested to meet with Suzanne Orsborn for a face to face meeting.

September 14 Pearl and Kay had another meeting with Suzanne and gave her 11 pages of answers to a *Detailed Checklist for Regulation Requirements* that would advise Government what should be included in the regulations for midwifery. She was given the *Outline of College Responsibilities for Implementation of Regulations under the Health Professions Act* completed as far as possible. At the AMNL September meeting members were asked for agreement with the four committee members to be College members and with no further volunteers, the meeting acclaimed these members to constitute the future College. Another document was for the College chair and another member to be represented on the future Council of the Health Professions Act. Pearl and Kay, offered and were accepted unanimously by those present at the AMNL meeting. Nomination forms had to be completed and sent with resumes to the Minister who would nominate the first Council members consisting of two representatives from each College and public members. These documents for the Council were also given to Suzanne at this meeting.

September 28 Pearl and Kay met with Suzanne Orsborn and gave her the updated copies of Philosophy, Code of Ethics, Competencies, Standards, and the new Midwifery Model for

midwifery practice in Newfoundland and Labrador. (These documents may be viewed on the AMNL web page.) Suzanne said that the plan is to have three professions (not midwifery) regulated by the end of the year and the others in the following three months. There are two 'prongs' working on midwifery being regulated. One 'prong' is for regulations and this is where we had been involved. The other 'prong' is how midwives will practice and fit into the health care system. This is being planned by an internal government group and so far midwives have not had input, although it was reported at the September NLPHA meeting that a report had been sent to the Minister. We have been given no definition of "grandparenting".
We are obtaining some information from other provinces on their initial assessment for registering midwives. There is no date for the next meeting with Suzanne, but in the meantime we have to write the College bylaws.

CMRC AIT Meeting, Edmonton, October 6, 2010
Pearl Herbert attended this meeting. There was discussion about the Partnership Agreement for Collaboration. This document varies from the original 2001 document, but restrictions can be imposed to protect the public interest. Certain information regarding practice can be shared among regulators but cannot be used as a reason to deny a worker, or impose conditions, unless there are on record complaints, or disciplinary, or criminal proceedings. Additional training can be asked when a person has not practiced the occupation within a specified period of time, and the worker can be required to demonstrate proficiency in either English or French. This then led to a discussion on Proof versus Verification of Professional Conduct Letter to be sent from one Registrar to another Registrar when a midwife is changing jurisdictions. Another document discussed was a guide that is being written "for midwives and regulators to assist in the labour mobility process throughout Canada."

Some Happenings Around the Country (excerpts from CAM Annual Report 2010)
Membership in the Canadian Association of Midwives (CAM) is through the provincial/territorial midwives associations. CAM is governed by a Board of Directors that is composed of representatives from each province and territory who are appointed by their respective midwives associations. The Executive Committee consists of the President, Past President or incoming President Elect, Vice President, Secretary and Treasurer. The National Aboriginal Council of Midwives (NACM) is also represented with two seats on the Board. There is one midwifery student representative on the Board. Board meetings take place by teleconference every 4-6 weeks and in person at annual CAM conferences; longer Board intensives are held twice yearly. CAM's Strategic Plan for 2010-2015 includes;
Goal # 1: Increase the influence of midwifery on the national health policy agenda. CAM has a seat on the Canadian Perinatal Surveillance System (CPSS) Steering Committee, SOGC Registered Midwives Advisory Committee, College of Family Physicians of Canada (CFPC) Maternity and Newborn Care Committee, Canadian Paediatric Society (CPS) NRP Steering Committee, SOGC Fetal Alcohol Spectrum disorder (FASD) Prevention Working Group.
Goal #2: Advance the growth and development of the midwifery profession.
Goal #3: Support Aboriginal midwifery and the return of birth to Aboriginal communities.
Goal #4: Advocate for normal childbirth, the midwifery model and primary maternity care as close to home as possible.

Goal #5: Strengthen International partnerships and outreach. For example, CAM developed the Ghislaine Francoeur Fund (GFF) for midwifery capacity-building projects in Haiti. CAM is a member organization of the International Confederation of Midwives (ICM). CAM has become a member of the White Ribbon Alliance for Safe Motherhood.
Goal #6: Strengthen the organizational capacity of CAM.

British Columbia

Midwives in BC are regulated and provincially funded. They work autonomously within community-based clinics and maintain clinical privileges to admit women under midwifery care to their local hospital. Choice of birthplace includes home or hospital settings. Midwives attend approximately 10% of total deliveries in BC. Home birth rates range from 25%-50% in various communities around the province where midwives are available to provide choice of birthplace. Midwifery in BC is expanding rapidly and midwifery services are now available to women in many rural communities throughout the province where one third of all practicing midwives are located. The Scope of Practice of midwifery in BC is growing in many areas including prescription, labour managements and specialized skills. The UBC Midwifery Education Program offers a four-year baccalaureate degree under the Faculty of Medicine. They are planning an accelerated stream to enable registered nurses to complete a midwifery degree in a shorter time frame. In 2010-2012 the federal government through HRSDC is funding the second pilot offering of the Multi-jurisdictional Midwifery Bridging Project (MMBP), the route to registration for internationally educated midwives (IEMs) that the College of Midwives of BC (CMBC) oversees for the Canadian Midwifery Regulators Consortium www.midwiferybridging.ca. (There is an option for RNs with a post nursing midwifery program lasting at least an academic year.) Currently in BC there are five registration categories and the CMBC is applying to add three new ones. There are now 168 registered midwives living and practicing in the province.
[Midwifery legislation came into effect in 1998 with 29 midwives.]

Alberta

Midwifery services in Alberta are in demand now that women are able to access government funded midwifery. Malpractice insurance is subsidized by the government. Rural Alberta is under served and the majority of midwives practice in the Calgary area. Midwifery services are under provincial jurisdiction. Alberta Health and Wellness oversees the provincial department of Alberta Health Services. Previously the province was divided into regions but now the goal is to have the same guidelines and regulations to cover all midwives in the province regardless of where they practice. Work has started on the Alberta College of Midwives which will replace the Midwifery Health Disciplines Committee. The mandate of the college will be overseeing education, registration and regulation of the profession. With the small numbers of registered midwives it will be a big task to develop these departments. The midwifery program at Mount Royal University in Calgary is still in progress. Currently many of the student midwives in Alberta are enrolled in the Midwifery College of Utah, a distance learning program that requires the students to have local preceptors for clinical skills. Midwives graduating from international programs must submit a portfolio and if accepted then go on to write a theoretical exam and complete OSCE's. Usually their status is a restricted registration while being supervised by a registered midwife for six to twelve months. At present there are 41 full and 9 restricted registered midwives and 28 students.
[Midwifery legislation came into effect in 1998 with 22 midwives.]

Saskatchewan

Midwifery care has been centered in the city of Saskatoon but is expanding into other communities as midwives become available. For recruitment of midwives to practice outside of the urban setting, education and training opportunities are offered. The Transitional Council (the Saskatchewan College of Midwives) continues to meet to review midwifery services in the province in addition to policies and communication strategies. Currently there are 10 members and three are midwives, but as member's terms come to an end they will be replaced by midwives. They are working with the government regarding providing insurance for student midwives who are receiving their education outside of Canada. At present there are 7 registered midwives and 7 midwifery students.

[Midwifery legislation came into effect in 2008 with 3 midwives.]

Manitoba

This year regulation was updated to allow midwives to give misoprostol, and to order IM diphenhydramine and flu vaccine. There are now 45 funded positions but recruitment is an on-going issue in many areas. Committees are being formed, one to co-ordinate recruitment and retention in the province, and another to share information between the different union representatives and to discuss on a provincial level the salary and benefits midwives would like. There are three different unions and therefore three separate collective agreements. Many Winnipeg midwives are working with consumers and the Women's Health Clinic and Winnipeg Regional Health Authority representatives to make the South Winnipeg Birth Centre a reality. The target date for opening is May 11, 2011. The centre is designed to accommodate 500 births per year and practice space for eight midwives. The University College of the North is offering a southern intake and eight students will be selected to attend a Winnipeg campus. The program has been adjusted to meet the needs of the south, including a curriculum that focuses more broadly on issues of cultural safety instead of specifically northern Aboriginal content, and an instruction/preceptorship model of teaching rather than mentorship.

[Midwifery legislation came into effect in 2000 with 11 midwives.]

Ontario

This year midwives are expected to attend more than 14,000 births. The number of midwifery clients choosing home birth continues to grow, with about 20% of clients having a home birth in 2009. This past year Ontario had a number of health bills that had an impact on midwifery. In December 2009, Bill 179 was passed, granting midwives greater scope of practice. Midwives are now able to communicate a diagnosis to clients, administer suppositories, take blood samples from fathers or donors, and intubate newborn babies. In September 2010 the Ontario Hospital Association, the Association of Ontario Midwives (AOM), and the College of Midwives of Ontario released the *Resource Manual for Sustaining Quality Midwifery Services in Hospitals*. http://www.ohatoday.com/Resources/Pages/Resources-09302010-MidwiferyManual.aspx

The AOM produced several resources this year to help midwives strengthen inter professional relationships, and has developed a number of new risk management resources to assist midwives in meeting changed legislative requirements, identifying quality of care issues and reducing risk in their communities. There are also six clinical practice guidelines. See the web site www.aom.on.ca for these publications. The Ontario government committed funding to increase midwifery education seats to 50%, bringing the current total across the consortium of Ryerson, McMaster, and

Laurentian Universities to 90 seats. Ryerson University has an accelerated stream for those with a prior health profession degree. In 2008 to 2009 the consortium received 650-700 applications. There are now 500 registered midwives in Ontario.
[Midwifery legislation came into effect in 1994 with 60 midwives.]

Quebec

The Regroupement Les Sages Femmes du Québec (RSFQ) is the main provincial association. In Québec, women covered by provincial Medicare have free access to midwifery services, which are entirely funded by the Department of Health and Social Services (MSSS). Québec midwives are hired on a contract by CSSS (previously the community health centres). They are not considered self-employed and CSSS pays for certain employment benefits, e.g. offices, secretarial assistance, equipment. If a CSSS has an agreement with a hospital, midwives have access to that facility and equipment when caring for women in the hospital setting. Midwives are allowed to take full responsibility for these births. The Québec government has adopted a new perinatal policy for 2008-2018 which makes provisions for midwives taking responsibility for 10% of all perinatal care and childbirth needs in the next 10 years. It also allows for the establishment of 13 new birthing centres and the provision of midwifery services to women living in vulnerable conditions. It is difficult to obtain the support needed to quickly get established. Québec now has 11 midwifery practices. There is a 4-year practicum-based baccalaureate program at the Université du Québec à Trois Rivières (UQTR). There are about 80 students currently registered in the 4-year program. Having passed the process of the Ordre des Sages-Femmes du Québec (OSFQ), the provincial College, 20 or more foreign-trained midwives are studying in UQTR's bridging program. There are 131 registered midwives and an additional 7 on special leave.
In Nunavik midwives have different kinds of contracts than those of their southern Québec counterparts. Nunavik midwifery services and education programs were established by the community in 1986 after a long battle to bring childbirth back to the North. The eight Nunavik midwives are now full members of the OSFQ. They provide complete health care services to women and families in their communities alongside 10 students and several part-time midwives from various southern parts of Canada and from Europe serving as mentors and preceptors. There are three birthing centres serving seven villages along the coast of Hudson Bay. Midwives care for 100% of pregnant women in this region and 85% of them give birth in their own village and in their own language. There are about 200 births per year. Midwives perform periodic routine tests of healthy women such as family planning, Pap tests, for STIs, etc., and offer follow-up child health care services. The scope of northern midwifery has increased to include emergency care and community care due to the remoteness of the region.
[Midwifery legislation came into effect in 1999 with 50 midwives.]

New Brunswick

There is no Association.
[Midwifery legislation came into effect in 2010 with no midwives.]

Nova Scotia

There are three model midwifery sites; the IWK tertiary care hospital in Halifax with 5,000 births per year, the South Shore Health, and Guysborough, Antigonish Strait Health Authority (GASHA) which has 400 births per year. Midwifery care is only available to women within these sites. Seven

funded midwifery positions were made available within these model sites with a long term vision of expansion within the existing sites or other districts, which will bring midwifery to more women and their families. The Midwifery Regulatory Council of Nova Scotia (MRCNS) comprises three midwives from the Association of Nova Scotia Midwives (ANSM), a nurse, a physician, three public members and the registrar. The Department of Health has established the Midwifery Evolution Implementation Nova Scotia (MEINS) committee with representation from the three model sites, a midwife, and others. There is a diversity among the three model sites, which leads to some differences in the model or the services currently available. The IWK has three full time equivalent (FTE) midwives with a caseload of 40 women per FTE per year, working out of a community-based clinic. Midwives offer both hospital and home births. Each client has a primary midwife, though the clients are shared within the team so that clients are familiar with all three midwives. The South Shore Health has 2 FTE midwives with a caseload of 40 women per FTE per year. A large percentage of clients are women who traditionally experience barriers to accessing care. Midwives offer home and hospital births and clients are seen in the community based clinic, as well as at home. GASHA has 2 FTE midwives who work 5 days per week on call, including weekends. Unlike the Canadian model of midwifery all uncomplicated pregnancies are shared within a collaborative team model with obstetricians, family doctors and midwives. Only hospital births are offered and midwives do not have a specific midwifery client caseload.
[Midwifery legislation was proclaimed in 2009 with 7 midwives.]

Northwest Territory

There are two midwives practicing in Fort Smith who provide prenatal and postnatal care for all childbearing families in the area with a community birth rate of 50-60%. There is one midwife with a solo practice in Yellowknife who provides services to 6-7% of women in her community. The three midwives are preparing to have their practices audited by an independent auditor. This task occurs every three years and fulfills a requirement for maintaining registration. Demand for midwifery services continues to outnumber the program's capacity. There has been continued interest from other NWT communities to obtain and provide midwifery services. However, there have been no additional midwifery positions funded this past year.
[Midwifery legislation came into effect in 2005 with 3 midwives.]

Nunavut

In 2006 Nunavut Arctic College commenced a four-year midwifery degree program. The successful completion of the third year gives a midwifery diploma and of the fourth year a midwifery degree in conjunction with Laurentian University. The program has been offered in Rankin Inlet, in Iqaluit, and now in Cambridge Bay.
[Midwifery legislation came into effect in 2009.]

Yukon

The Government has completed a public consultation on midwifery and will decide if midwifery will be regulated under the Health Professions Act.

Prince Edward Island

The PEI Midwives Association is an active member of Birthing Options Resource Network (BORN), a coalition of parents and doulas who lobby for birthing options for PEI women. CAM

has also been lobbying for midwifery and a letter has been received by both CAM and BORN indicating that a task force would be established to consider how midwifery could be implemented in the province.

National Working Group for the Emergency Skills Workshop (ESW) for Midwives
(Summary)
The CAM Midwifery ESW Program provides workshops to build, refresh and practice skills and decision making in managing birth emergencies for Midwives across Canada. This year the CAM Emergency Skills Working group continued efforts in unifying ESW across Canada. A licensing agreement between CAM and the Association of Ontario Midwives (AOM) and the provinces was finalized at the 2009 CAM conference in Winnipeg. The goal is to build a national Midwifery Emergency Skills program that serves midwives and their communities in order to support the safest clinical care possible for women and their families. The AOM holds the copyright of the Midwifery ESW Workbook. A 2009 revision of the Workbook was published and distributed to ESW instructors this past year and CAM has funded the translation of the Workbook into French. Each province may make amendments to the content or create addendums to reflect the needs and standards of their province. A fee for each participant is forwarded to the CAM office, which then contributes a participant fee to the AOM to be used for continued revisions of the Workbook. Each provincial midwifery association will continue to organize their own courses, train their own instructors and distribute course completion cards. All ESWs are organized through the provincial associations. The Midwifery ESW meets the requirements of provincial regulatory bodies for Continuing Education Courses in managing birth emergencies across Canada.

Maternal and Newborn Outcomes in Planned Home Birth vs Planned Hospital Births: A Meta analysis - (an example of poor research methods.)
Midwives should know the basics of critiquing research so as to identify when there are problems. One way is when the findings are not what would generally be expected, then the question should be asked, how were these findings arrived at? Over the years there have been a few examples of poor methods and skewing of findings to prove a point. There was the study headed by Mori et al. in Britain and the refuting of this by a National Childbirth Trust team. (See AMNL Newsletter, No. 49, September 2009, page 9). Now there is research from the USA by Joseph R. Wax et al. where they endeavour to show that home births are not safe for neonates. Currently USA physicians are against midwives attending home births and so Wax et al. did a meta-analysis of previous studies on home births, to show why home births should not occur. Instead of just taking the good research they used previous flawed studies and put them all together. They then came to the conclusion "Less medical intervention during planned home birth is associated with a tripling of the neonatal mortality rate." *AJOG, 203*(3), 243, September 2010 ejournal. "Home deliveries in developed Western nations are often associated with excess perinatal and neonatal mortality, particularly among non anomalous term infants." *Obstetrical & Gynecological Survey, 65*(2), 132-140. Of course, the American newspapers made much of these findings.
Dr. Michael Klein from BC told the CBC News that this is "a politically motivated story", and if you put garbage in you get garbage out, and the garbage from this study stinks.
(Jenniferblock.com/wordpress/?p=122). Also see *Science & Sensibility >> Meta-analysis: The*

wrong tool (wielded improperly) July 12, 2010. Although Dr. Wax et al. acknowledged the consistent findings of low perinatal and neonatal mortality in planned home births in the best quality studies they did not emphasize or even mention this in their conclusion. They did not mention who the birth attendants were. The conclusions do not match the study (mothering.com/jennifermargulis/tag/joseph-r-wax) July 21, 2010.
The British National Childbirth Trust has a critique of the Wax study on its web site, along with other articles regarding Place of Birth.
(http://www.nct.org.uk/about-us/what-we-do/policy/choiceofplaceofbirth)
[These reports and articles can be obtained by Googling.]

CAM Conference 2010 - The Place of Birth, Edmonton, October 6-8. (From Pearl's notes.)
The Canadian Midwifery Regulators Consortium (CMRC) annual face-to-face meeting was held October 4 and 5 (Pearl attended the October 5 afternoon meeting), followed by the AIT Labour Mobility meeting on October 6. The CAM AGM was also on October 6 but this was not attended as Kay, AMNL representative to CAM, was ill and unable to go to Edmonton.
On Tuesday, October 5, prior to the CAM Conference there was a workshop "V-Day - What's going on down there? Everything you wanted to know about the vagina but were afraid to ask". Midwives who went to this workshop found it very useful as it included anatomy and physiology of the vagina, practice suturing, and helpful advice about preventing problems and how to deal with them if they occurred. These preconference workshops usually provide practical information.
The CAM Conference started the evening of Wednesday, October 6.
There were greetings from various dignitaries, including Bridget Lynch, ICM President. Bridget mentioned the trend for midwifery becoming linked to nursing in English speaking African countries, where midwifery training now is moving to 3 months after the nursing training. The French-speaking countries are still maintaining the usual sages-femme training.
The Place of Birth, Eileen Hutton RM, Ontario, was the speaker. She spoke on the attitudinal and social changes that were occurring, including the normalisation of cesarean sections, concerns v continence, low tolerance for fetal risk and malpractice litigation. A survey of 3680 first time entering students, for all faculties, at UBC found that 9% considered that they, or their partner, would prefer a cesarean section. This opening presentation was followed by a reception.
The next day, October 7, several presenters mentioned the Wax study. Judith Rooks CNM, spoke about research studies, including the one by Wax et al. She also mentioned other studies, such as a 1974 to 1976 study in North Carolina that did not show the whole story. In this study birth and death certificates were used but when the parents were interviewed they gave information that was not on the certificates, including that the researchers had taken the name of the person who reported the birth as being the attendant at the birth, when often this was not the case. Patti Janssen RN, carries out research in BC. A four year study of 2,899 women in BC compared the cost of planned home birth vs planned hospital birth in BC. She spoke about planned home birth with a midwife in attendance, and compared this with a midwife and physician attending planned hospital births. There are studies of place of birth but not all show whether or not the place was planned. SOGC (2003) states that more research is needed into the safety of home births, whereas RCOG supports home birth, and ACNM (2005) states that women have the right to have a home birth, but ACOG (2008) considers that all births should be in hospital, similar to ANZOG. In BC the perinatal death rate is less than one per thousand births. George Carlson MD, asked, What do I

know? How do I feel? The SOGC definition of normal birth does not say where they should occur. Equipose means there is genuine uncertainty and outcome can be anything.
Beth Murray-Davis RM, showed that contra indications to home births differ from location to location, and from country to country. In the UK there are no single criteria among the various Trusts (Regional Health Boards) but the NICE guidelines are stricter. New Zealand has implied contraindications. Midwives should document their decision making. There are grey areas with inconsistencies and conflict between practitioners. Ank Dejong midwife, gave some guidelines from the Netherlands. She said that one always has to prove home is safer than hospital, but hospitals do not have to do this. She asked if home birth in the Netherlands is a thing of the past? The percentage of home births is 23% and declining and the perinatal mortality is increasing. Small hospitals are closing. Ambulance staff do not lift patients and midwives may have to call the fire brigade if the woman cannot walk or be wheeled to the ambulance. The midwife's case load is reduced from 120 to 105 women per year. Home births have been expanded to medium risk so as to provide more continuity of care.
Two midwives from Ontario, Kathi Wilson and Michelle Kryzanauskas, presented their findings regarding rural home birth outcomes. The College of Midwives of Ontario has no regulation concerning distance from a hospital. The coroner has never made any recommendation regarding distance. They used data from the Ontario billing system, and postal code information to calculate distance from home to hospital. One midwife practices in an area covering 9,000 sq. km and the other in an area with a mixed rural area and a larger town that covers 7,250 sq. km. In this part of Ontario they see many women from a culture that strongly supports home births. The midwives recommended that further analysis of large provincial databases should be undertaken in order to support the continued provision of rural homebirth.
Tracey Hillier, mother and GP, spoke about shared care with a family physician and a midwife. In hospital many people but at home few. Women make choices and have their expectations.
Vicki Van Wagner RM, spoke about how midwives can feel disempowered in hospital settings, and yet it is more important to women giving birth in institutions, for midwives to claim their place and provide autonomous midwifery led care. In Canada there is good consultation with physicians, compared too many other places. Good practice in the home and birth centre should also be the norm for practice in the hospital. Midwives need to be included in the making of hospital policies. Midwives need to claim their place and respect in the hospital. Collaboration means mutual respect. To take responsibility and be part of the team, and respect that there may be different ways of dealing with situations. It is important for midwives to attend hospital rounds. Liability is not an issue when people communicate, and parents are less likely to sue when the woman has received continuity of care and knows the midwife.
Designs of birthing spaces and the environment affect labour. Deborah Davis a faculty member at the University of Technology, Sydney, Australia, has been studying birthing rooms. She used the National Childbirth Trust research and a focus group to develop the Birth Unit Design Spatial Evaluation Tool (BUDSET) that was tested in six birth units in New South Wales. She found that there is potential for improvement with simple, low-cost modifications, such as moving the bed from the centre of the room. In one unit that had floor to wall carpet the head nurse found that a way to stop electrical fetal monitoring and all women being told to lie on the bed, was to put the monitors in a cupboard at the far end of the corridor. It took effort for the midwives to pull the monitors from the cupboard, along the carpeted floor to the room, and so unless necessary the midwives stopped routinely using them. Ellen Hodnett RN, spoke on the birth environment and

asked the question why do women go out of labour when admitted to hospital? Women are receiving care from nurses, who they may not have met before. Also nurses work shifts, and have other duties besides being with one woman. The environment may look very clinical, and there are different sounds and smells. Snoezelen, or controlled multi sensory stimulation, delivers stimuli to various senses, using lighting effects, colour, sounds, music, scents, etc., and there can be a combination of different materials and posters on the wall. For Women this is soothing when they are Pregnant and Labouring in an Ambient Clinical Environment. Even those working on the unit find this relieves stress.

Andrew Kotaska MD, from Yellowknife where they have about 500 births a year, 50% from the town and 50% from elsewhere, spoke about "Informed Consent: When Autonomy and Beneficence Collide". He gave some definitions. Autonomy is an individual's right to decide their health care path. Beneficence is the imperative to do what is best. (Risk of going in a space shuttle is 1 in 70, but for most birth situations the risk is much less). Recommend is to endorse a preferred clinical course of action. Coerce is to compel by force of authority. Between Recommend and Coerce is Autonomy - Honesty - Detachment. Types of Recommendations are: 1. Force treatment; 2. Recommend treatment; 3. Offer treatment; 4. Recommend against treatment; 5. Refuse treatment to a patient. He then gave some mini scenarios of decisions where women declined recommendations and asked the audience how they would deal with these situations.

Healthcare Insurance Reciprocal of Canada (HIROC)

According to the information sheet, HIROC was "founded in 1987 and has grown to become the largest healthcare liability insurer in Canada. With subscribers representing more than 600 health care facilities such as hospitals, nursing homes, community health centres, and midwifery groups." When in Edmonton for the Canadian Association of Midwives meeting, Pearl met with the HIROC midwifery insurance representatives to obtain information requested for regulating midwifery in this province.

The four Newfoundland and Labrador Regional Health Authorities, Eastern, Central, Western and Labrador Grenfell, have HIROC insurance. Each health authority has their own policy. Each of these policies contains the clause "does not cover midwife care". When midwifery is regulated, this clause can easily be removed. The insurance will cover midwives for $10 million or more depending on the Health Authority's policy. Midwives then buy an extra coverage to pay for any lawyer or other legal fees, which are not covered by the Health authority.

HIROC and the Canadian Medical Protective Association have a "Joint Statement on Liability Protection for Midwives and Physicians", see www.hiroc.com

The Canadian Nurses Protective Society, and insurances for which active practicing registered nurses pay with their ARNNL annual fee, cover nurses within the scope of the nursing practice. In Canada, midwifery is not considered to be a part of nursing.

The Royal College of Midwives has an insurance included in their full membership BUT there is no reciprocity between Canada and Britain so this insurance does not cover midwives in Canada.

Sandall, Jane et al. (2009). Discussions of findings from a Cochrane review of midwife-led versus other models of care for childbearing women: continuity, normality and safety. *Midwifery, 25*,8-13.

ASSOCIATION OF MIDWIVES OF NEWFOUNDLAND and LABRADOR
APPLICATION FOR MEMBERSHIP
2011

Name: _____
(Print) (Surname) (First Name)

All Qualifications: _____

Full Address: _____

_____

Postal code: _____ Telephone No. _____
(home)

Telephone No. _____ Fax No. _____
(work)

E-mail Address: _____

Work Address: _____

_____

Area where working: _____

Retired: _____ Student: _____ Unemployed: _____

List of Organizations of which you are a member (the Association receives requests from various organizations for representatives to review articles, attend conferences, be on committees). Your name would not be forwarded without your consent.

Provincial: _____

National:_____

International: _____

Would be interested in participating in a research project if asked: Yes ____ No _____

For midwives who pay $75.00 ($20.00 AMNL membership fee and $55.00 CAM membership fee):

If you do not agree to your address, postal and Internet, being released to CAM tick here: No release: _____

_____

I wish to be a member of the Association of Midwives and I enclose a cheque/money order from the post office

for: $_____
(Cheques/money orders only (no cash) made payable to the Association of Midwives of Newfoundland and Labrador). Membership and financial year from January 1 to December 31.

To be a member of AMNL and receive the electronic quarterly AMNL newsletter **$20.00**
For AMNL members also to be members of Canadian Association of Midwives (CAM) add **$55.00** (Total **$75.00**)
[$75.00 includes AMNL membership and CAM membership, including the 4-monthly CAM research/practice journal.]
Membership for those who are residing outside of Canada **$20.00.** Correspondence will be by e-mail.

Signed: _____ Date: _____
Return to: Pamela Browne, Treasurer, Box 1028, Stn. C, HVGB, Labrador, NL, A0P 1C0